DRAFT MINUTES

Name of Meeting: Managed Care Advisory Committee

Date of Meeting: Wednesday, November 5, 2003

Length of Meeting: 4:15 – 5:45 PM

Location of Meeting: DMAS Board Room

Purpose of Meeting: The Semi-Annual Managed Care Advisory Committee (MAC) meeting was held with the attendance of various providers, advocates, and state agency staff, MCO representatives and others. The meeting is designed to discuss the status of the Medicaid managed care programs in Virginia, present information on current studies, projects, or issues and encourage open discussion and questions.

DMAS Attendees:

Patrick Finnerty	Cynthia Jones	Cheryl Roberts
Bryan Tomlinson	Mary Mitchell	Jim Cohen
Olivia Howell	Linda Nablo	Diane Hankins
Javier Menendez	Paula Margolis	Cindy Bowers
Diane Hankins	Katina Goodwyn	Donna Garrett
Alissa Nashwinter		

Other Attendees:

Robert Hurley	Raymona Barnes	Joseph Boatwright, MD
Nancy Bullock	Joan Corder-Mabe	Doug Gray
Bonita Hogue	Brett Jackson	Vickie Johnson-Scott
Julie Locke	April Kees	Joy Lombard
Jim Parrott	Megan Philpots-Padden	Helen Plaissance
Rick Shinn	Sherrie Smith	Rebecca Snead
Robert Sonnessa	Caryn Weir-Wiggins	Wayne Reynolds
Joy Yen, MD	Kim Barnes	Tim Jones

Call to Order

Bryan Tomlinson, Director Health Care Services Division, DMAS, opened the meeting and began by discussing that the upcoming presentations reflect hot and current topics in Managed Care. Introduced Dr. Robert Hurley and Rebecca Snead.

Cheryl Roberts, Deputy Director for Operations, DMAS, gave a brief history of the Managed Care Advisory Committee. Ms. Roberts discussed the draft of the Annual Performance Report and requested volunteers to review and comment on it in a timely manner. She also announced that Virginia Premier Health Plan had a very positive JCAHO accreditation review/interview.

Mr. Finnerty, Agency Director, DMAS, welcomed and thanked everyone for coming and gave additional background on the two presenters.

Mr. Tomlinson introduced Dr. Robert Hurley and presented a brief bio on him.

Dr. Robert Hurley, VCU, gave a presentation on Profiting from Proficiency: The Growing Importance of Medicaid-focused Managed Care Plans (A copy of the presentation follows the minutes.)

The full report is available on the Center for Health Care Strategies (CHCS) website www.chcs.org

Dr. Hurley began by discussing how health plans and states have encountered adversarial times and there is a need for partnership. Year 2005 will be a pivotal time for health plan finances and states will still in budget crisis mode.

The presentation reflects the third in series of studies for the Center for Health Care Strategies on the Medicaid Managed Care Marketplace. Robert Hurley, Michael McCue and Askar Chukmaitov conducted the study at VCU with funding from CHCS.

Trends in Medicaid are:
- Medicaid agencies remain strongly committed to HMO product/model
- Declining participation on commercial plans
- Increasing percentage of beneficiaries enrolled in plans with 75% of more Medicaid members
- Rise of publicly traded Medicaid-focused plans (Amerigroup, Centene, Molina, United/AmeriChoice)
- Concerns and questions about adequacy of performance of Medicaid-focused plans

These transitions are occurring due to commercial plans finding Medicaid to be a difficult market to adjust to and achieve success and the plans have dropped or deemphasized HMO's. Medicaid-focused plans have grown in size and sophistication and have become more proficient. A substantial number of Medicaid-focused plans are still provider-sponsored. Also investors have identified Medicaid as a market with opportunities for profits and growth.

Financial performance indicators are: Medical benefits ratio, amount of insurance paid out in medical expenses. Administrative cost ratio, amount of insurance revenues paid out in administrative costs. Operating profit margin, amount of profit earned form insurance revenues.

Non-financial performance indicators are: Composite score from the enrollee survey, overall rating of health plan, getting needed care, customer services and selected HEDIS prevention rates.

The analytical findings were: The product line profitability is modest and generally consistent across focus and ownership types and medical benefits (loss) ratios are comparable; provider sponsored plans may pay providers a little better. Some evidence of economies of scale is evident. Medicaid focused plans trail other plans in member satisfaction but similar on other performance measures and for-profit plans have better member ratings but not-for-profit plans score better on clinical and access measures.

The conclusions and implications are that further reliance on Medicaid-focused plans seems inevitable. Variation in plan participation across states remains. Concerns about the weakness of Medicaid focused plans are not borne out. Remaining plans are stronger, more sophisticated

and compliant. States and surviving plans are more interdependent. Investor-owned firms bolster market both directly and indirectly and are likely to grow revenues but it will be challenging to sustain profitability. Durability of prepaid Medicaid managed care market remains uncertain if state budget problems persist or worsen.

There were no questions for Dr. Hurley.

Rebecca Snead, Executive Director of the Virginia Pharmacists Association was introduced with a brief bio on her.

Rebecca Snead, VA Pharmacists Association gave a presentation on Medicaid Pharmacy Programs: Preparing for the Future (A copy of the presentation follows the minutes.)

States are facing deficits in the range of $70 – 485 Billion for FY 2004. Between 1997 and 2000 Medicaid spending rose 7.7% per year and prescription drug spending rose 18.1% per year.

Three main cost drivers in the current environment are; Price increases for existing drugs, new drug launches, and increased utilization of new and existing drugs.

Current focus for managing the pharmacy benefit are; PDL, Target high utilizers (9 or more initiative), limit 34 days supply, increase co-pay for brand name drugs, and decrease reimbursement to pharmacies.

Future focuses for managing the pharmacy benefit are:
- Generic utilization – Dispensing generic drugs at a 52.0% rate has a potential cost saving of approximately $4,256,967, at 55.0% rate the potential savings could be $17,618,427.
- Prescribing patterns (focus on e-prescribing) - Electronic prescribing provides the provider with medication history to help make informed decisions regarding appropriate therapy. It also provides the ability to perform true prior authorization and to access real-world Medicaid pricing information.
- Persistency & compliance – A 2003 World Health Organization report states that only about 50% of people follow doctor's orders about taking their prescription drugs, and that number is as low as 40% for some conditions. The non-adherence appears to be the same across income and education demographics, and reasons include fear of side effects and not understanding doctor's orders.
- Self-care – A move from urgent car to self-care OTC medication is used to treat over 450 medical conditions, many of which occur 10s of millions a time per year (e.g., common cold, headache, fever, motion sickness, acne).

There were a few questions for Ms. Snead during the presentation in regards to the e-prescribing and electronic system.

The meeting was adjourned at 5:45 PM

Profiting from Proficiency: The Growing Importance of Medicaid-focused Managed Care Plans

Robert Hurley

Michael McCue

Askar Chukmaitov

Virginia Commonwealth University

Funded by the Center Health Care Strategies, Inc.

3rd in Series of Studies for the Center for Health Care Strategies on Medicaid Managed Care Marketplace

- 1997— *Medicaid and Commercial HMOs: An At Risk Relationship*
- 2000— *Partnership Pays: Making Medicaid Managed Care Work in Turbulent Environment*
- 2003—Current study

Trends

- Medicaid agencies remain strongly committed to HMO product/model
- Declining participation of commercial plans
- Increasing percentage of beneficiaries enrolled in plans with 75% of more Medicaid members
- Rise of publicly traded Medicaid-focused plans

(Amerigroup, Centene, Molina, United/AmeriChoice)

- Concerns and questions about adequacy of performance of Medicaid-focused plans

Why is Transition Occurring?

- Commercial plans find Medicaid to be difficult market to adjust to and achieve success
- Many commercials have dropped or deemphasized HMO product (not selling what Medicaid is buying)
- Medicaid-focused plans have grown in size and sophistication and become more proficient
- Substantial number of Medicaid-focused plans are still provider-sponsored
- Investors have identified Medicaid as market with opportunities for profits and growth

Study Questions

1. What are implications of transition to Medicaid-focused plans?
2. How does the financial and non-financial performance of Medicaid focused plans compare to other plans in the Medicaid product line?
3. Given budget crises in states, what are contemporary market dynamics?

Study Methods and Data Sources

1. Analysis of financial performance indicators for Medicaid product line

(Interstudy—NAIC filings)

2. Assessment of performance of publicly traded Medicaid focused plans for Medicaid enrollees

(10 K—SEC filings)

3. Analysis of non-financial performance indicators

(NCQA Quality Compass and state specific reports)

4. Interviews in 13 states with Medicaid agency, plan officials, trade associations, and advocacy groups

(Interview protocol)

Financial Performance Sample Profile

Characteristics	Medicaid-focused	Multi-product
Plans	75	108
Median enroll.	49,000	121,000
Provider-Affilated	30	27
Non-Provider	45	81
For profit	46	70
Not-for-profit	29	38

Financial Performance Indicators

- Medical benefits ratio
  - Amount of insurance revenues paid out in medical expenses
- Administrative cost ratio
  - Amount of insurance revenues paid out in administrative costs
- Operating profit margin
  - Amount of profit earned from insurance revenues

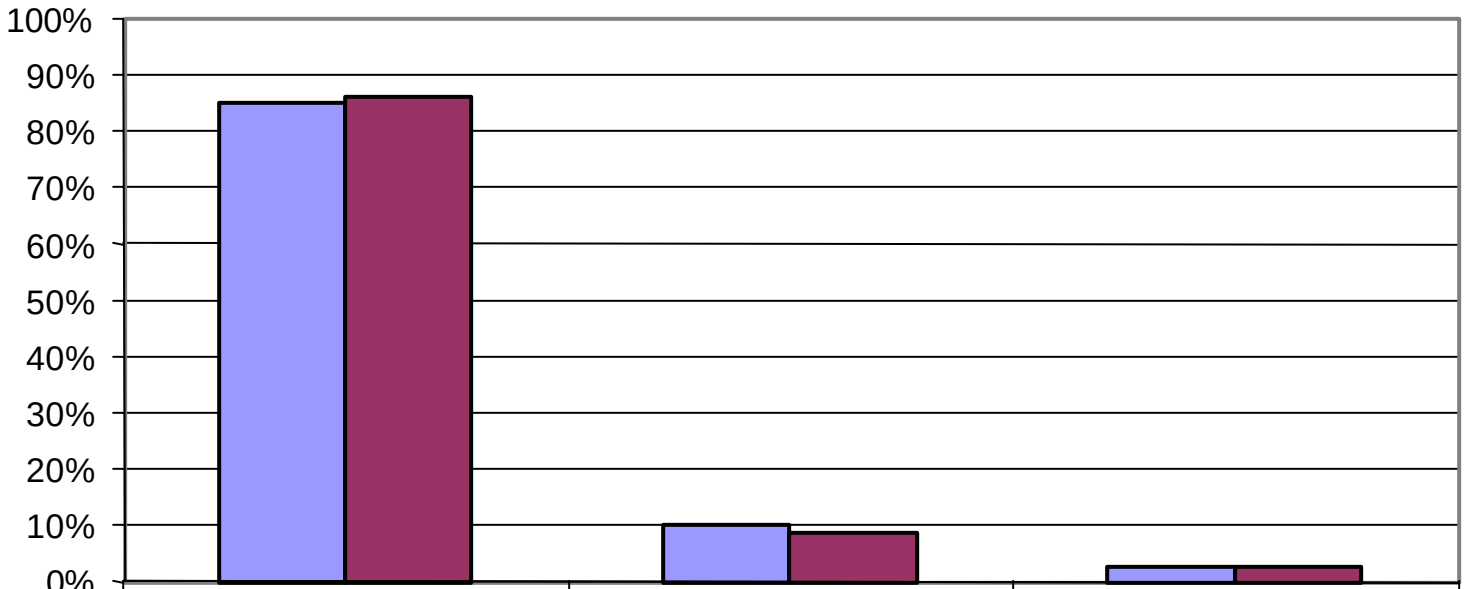
Non-Financial Performance Indicators

Composite score from enrollee survey

- Overall rating of health plan
- Getting care quickly
- Getting needed care
- Customer service
- Selected HEDIS prevention rates

Findings—Financial Performance

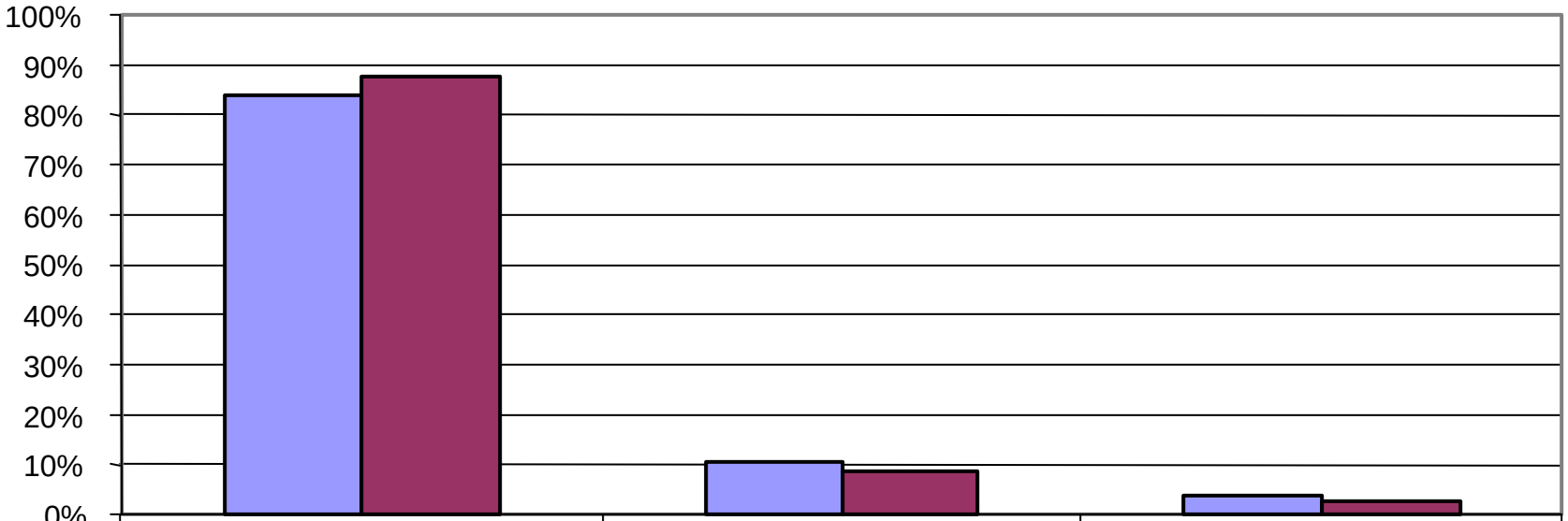
Multi-Product vs. Medicaid Focused Plans



	Medical Benefits Ratio	Administrative Cost Ratio	Operating Profit Margin
Medicaid Focused	85%	10%	3%
Multi-Product	86%	9%	3%

Findings—Financial Performance

For-Profit vs. Non-Profit Plans



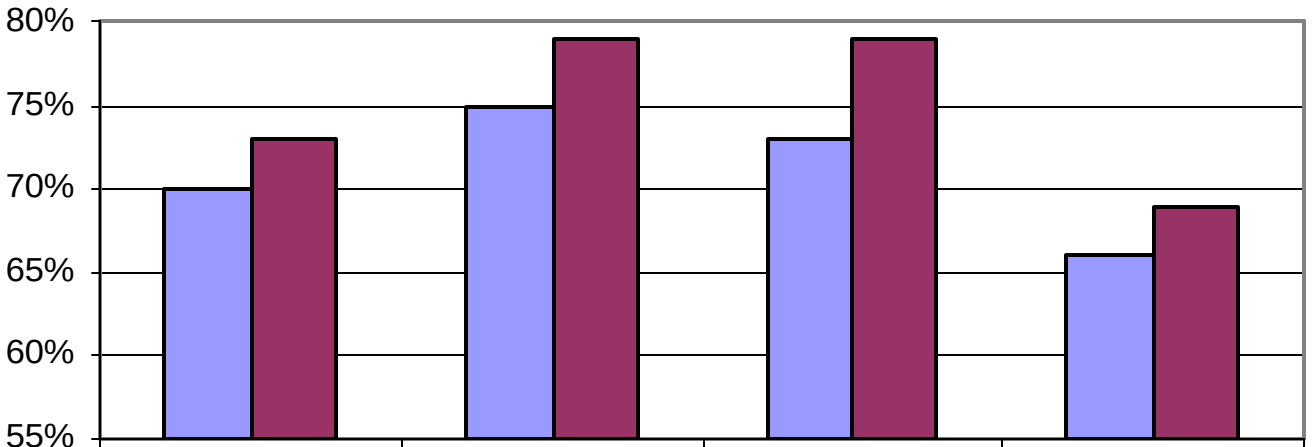
	Medical Benefits Ratio	Administrative Cost Ratio	Operating Profit Margin
For-profit	84%	11%	4%
Non-profit	88%	9%	3%

Non-Financial Performance Sample Profile

Characteristics	Medicaid-focused	Multi-product
Plans	18	41
Median enroll.	76,000	225,000
Provider-Affilated	6	9
Non-Provider	12	32
For profit	8	21
Not-for-profit	10	20

Findings— Non-Financial Performance

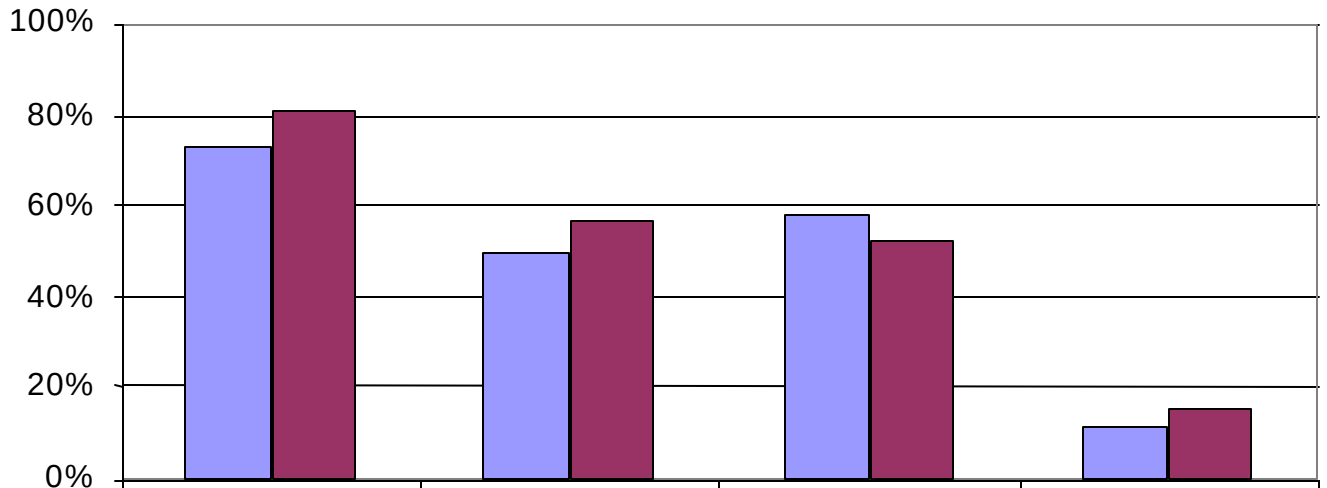
Medicaid Focused vs. Multiproduct Plans
NCQA Rating Measures



	Rating of Health Plan	Getting Care Quickly	Getting Needed Care	Customer Service
Medicaid Focused	70%	75%	73%	66%
Multi-Product	73%	79%	79%	69%

Findings— Non-Financial Performance

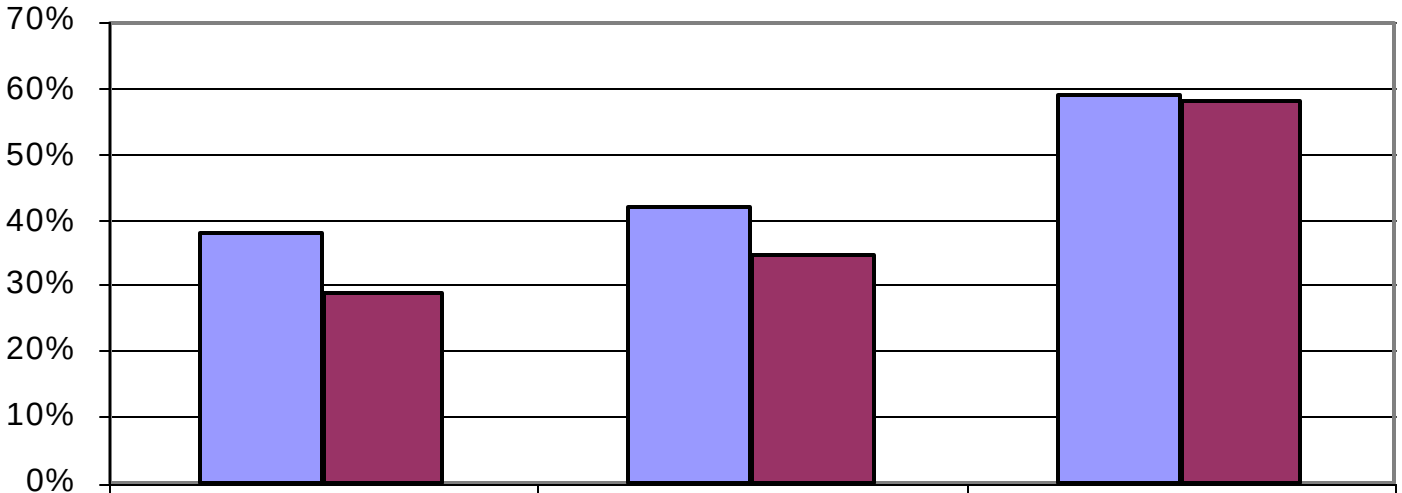
Medicaid-focused v. Multi-product Clinical Indicators



	Prenatal Care	Postnatal Care	Child Immunizations	Adolescent Immunizations
Medicaid Focused	73%	50%	58%	11%
Multi-Product	81%	57%	52%	15%

Findings— Non-Financial Performance

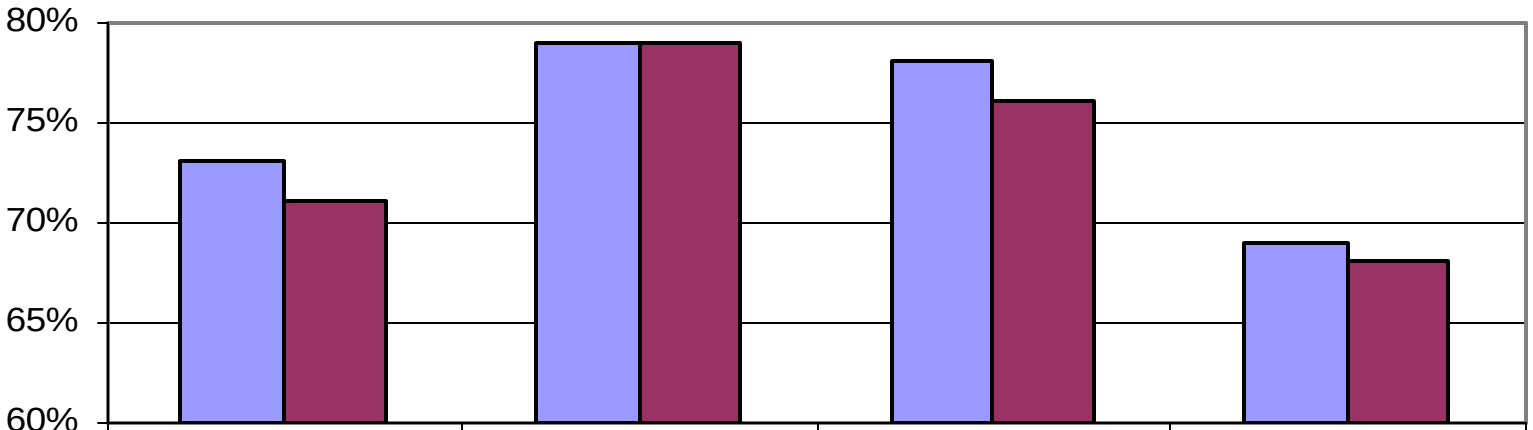
Medicaid-focused v. Multi-product Access Indicators



	Adolescent Well Visits	Well Child Visits, 15 months	Well Child Visits, 3-6 yrs
Medicaid Focused	38%	42%	59%
Multi-Product	29%	35%	58%

Findings— Non-Financial Performance

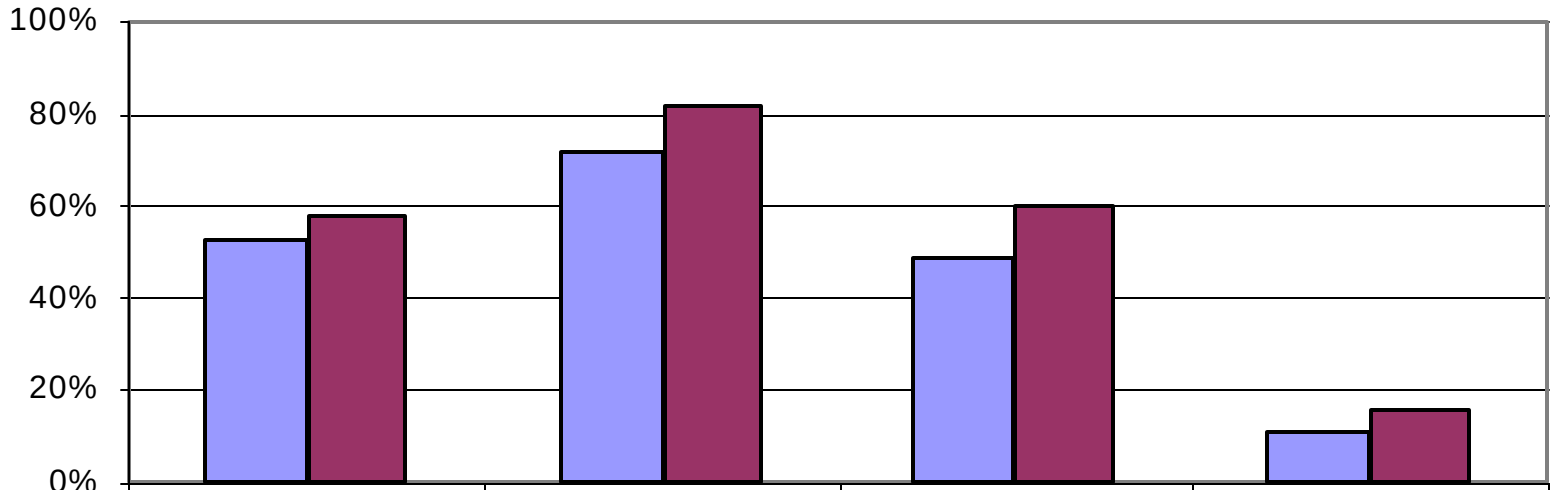
For-Profit vs. Non-Profit Plans
NCQA Rating Measures



	Rating of Health Plan	Getting Care Quickly	Getting Needed Care	Customer Service
For-profit	73%	79%	78%	69%
Non-profit	71%	79%	76%	68%

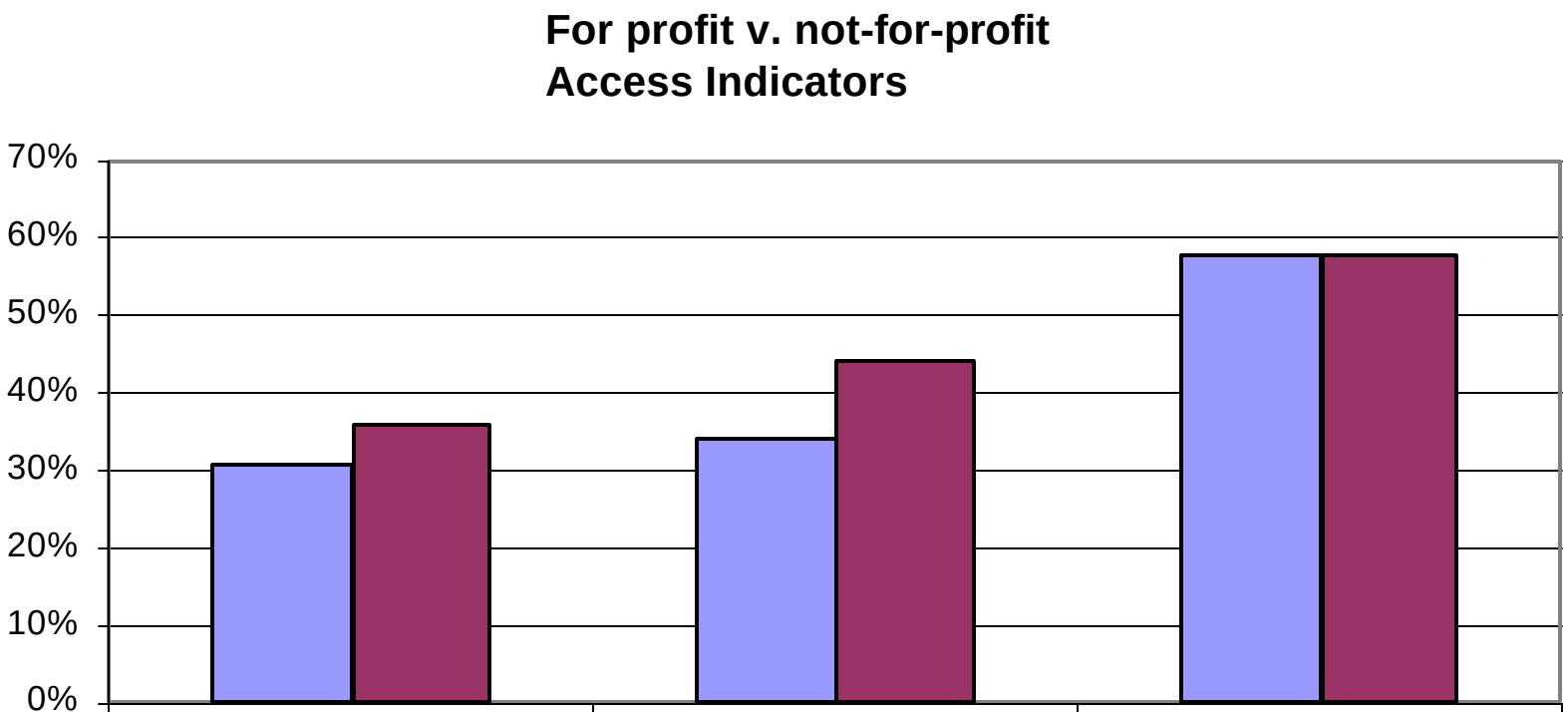
Findings— Non-Financial Performance

For-profit v. Not-for-profit
Clinical Indicators



	Prenatal Care	Postnatal Care	Child Immunizations	Adolescent Immunizations
For-Profit	53%	72%	49%	11%
Non-Profit	58%	82%	60%	16%

Findings— Non-Financial Performance



	Adolescent Well Visits	Well Child Visits, 15 months	Well Child Visits, 3-6 yrs
For-Profit	31%	34%	58%
Non-Profit	36%	44%	58%

Analytical Findings-Summary

- Product line profitability is modest and generally consistent across focus and ownership types
- Medical benefits (loss) ratios are comparable; provider sponsored plans may pay providers a little better
- Some evidence of economies of scale evident
- Medicaid focused plans trail other plans in member satisfaction but similar on other performance measures
- For profit plans have better member ratings but not-for-profit plans score better on clinical and access measures

Findings--Interviews

- Medicaid-plan relationships have improved markedly
- Plan participation trends driven by broader market trends, not explicit state policy
- Success requires concentration on Medicaid-market
- Medicaid-focus means more aggressive outreach, more culturally competent provider networks, stronger medical management, targeted programs for low income persons lacking social supports

More interview findings

- Financial and non-financial performance among plans becoming more homogeneous due to contract requirements and enforcement
- Budget crisis placing considerable stress on all parties
- Many states have frozen rates or rolled them back in current year
- Plans resigned to accepting current crisis
- Next year more telling—if rate increases fall below medical trends

Study Limitations

- Single year
- State variation
- Data
- Representativeness
- Quality indicators
- Phone survey done during period of budget uncertainty

Conclusions and Implications

- Further reliance on Medicaid-focused plans seems inevitable
- Variation in plan participation across states remains
- Concerns about weakness of Medicaid focused plans not borne out
- Remaining plans stronger, more sophisticated and compliant

Conclusions and Implications

- States and surviving plans more interdependent
- Investor-owned firms bolster market both directly and indirectly
- Investor-owned firms likely to grow revenues but sustaining profitability will be challenging
- Durability of prepaid Medicaid managed care market remains uncertain if state budget problems persist or worsen

Medicaid Pharmacy Programs

Preparing for the Future

Rebecca P. Snead

VIRGINIA PHARMACISTS ASSOCIATION

Overview

- Briefly recap current environment
- Present four areas for future focus
  - *Generic utilization*
  - *Prescribing patterns*
    - **Focus on e-prescribing**
  - *Persistency & compliance*
  - *Self care*

Current Environment - Pressure on State Budgets

- **States are facing deficits in the range of $70 to $85 Billion for FY2004.**
- **More than 2/3rd of states report shortfalls for 2003, totaling at least $17.5 Billion.**
- **Between 1997 and 2000:**
  - *Total Medicaid Spending rose 7.7% per year*
  - *Prescription Drug Spending increased by 18.1% per year*

Current Environment – The Big Three Cost Drivers

- **Price Increases for Existing Drugs**
  - ***20%** of Expenditure Growth*
- **New Drug Launches**
  - ***40%** of Expenditure Growth*
- **Increased Utilization of New and Existing Drugs**
  - ***40%** of Expenditure Growth*

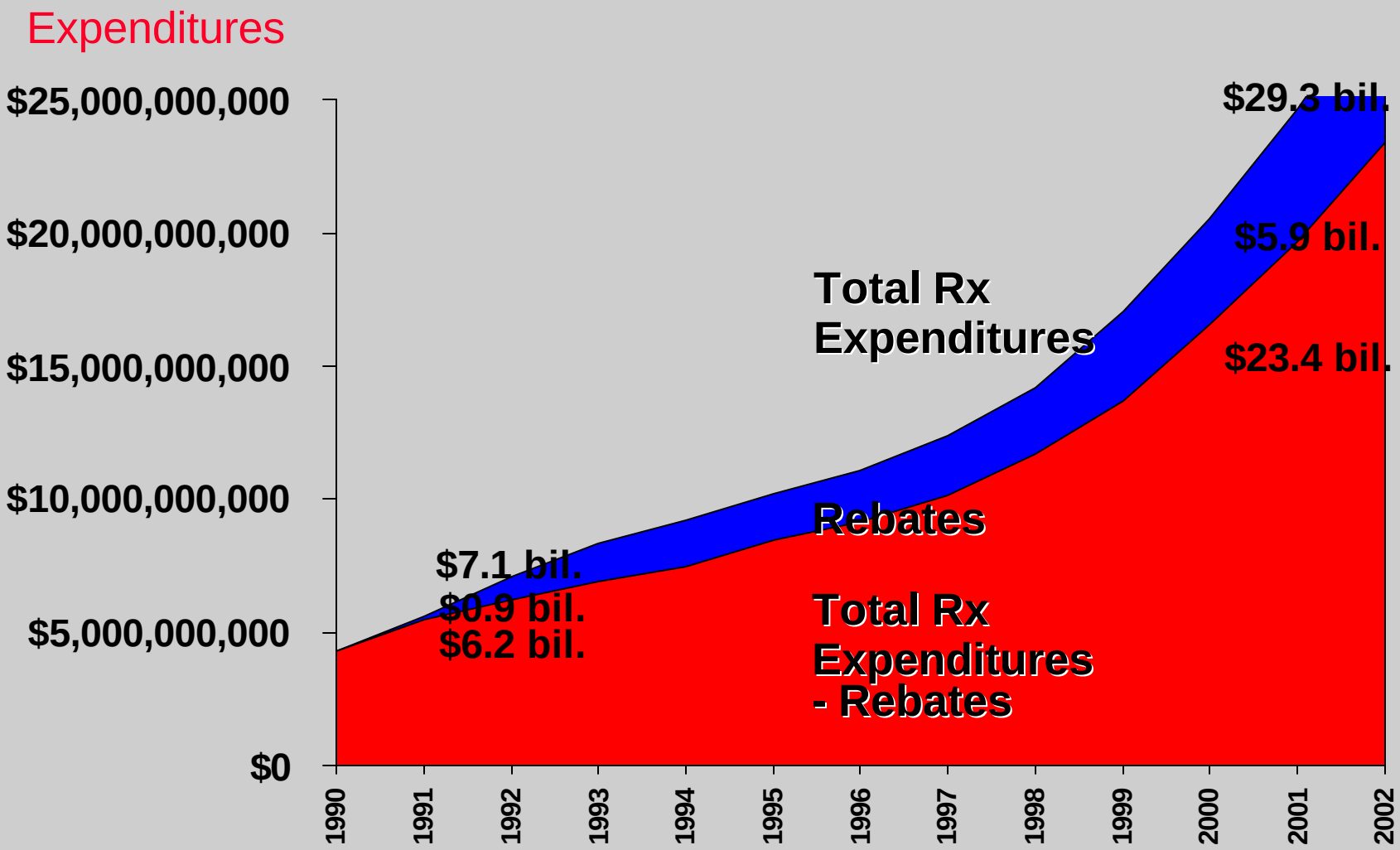
Factors Influencing Drug Expenditures

Total Drug Expenditures =

[Population x Intensity x Efficiency] + Admin. Costs

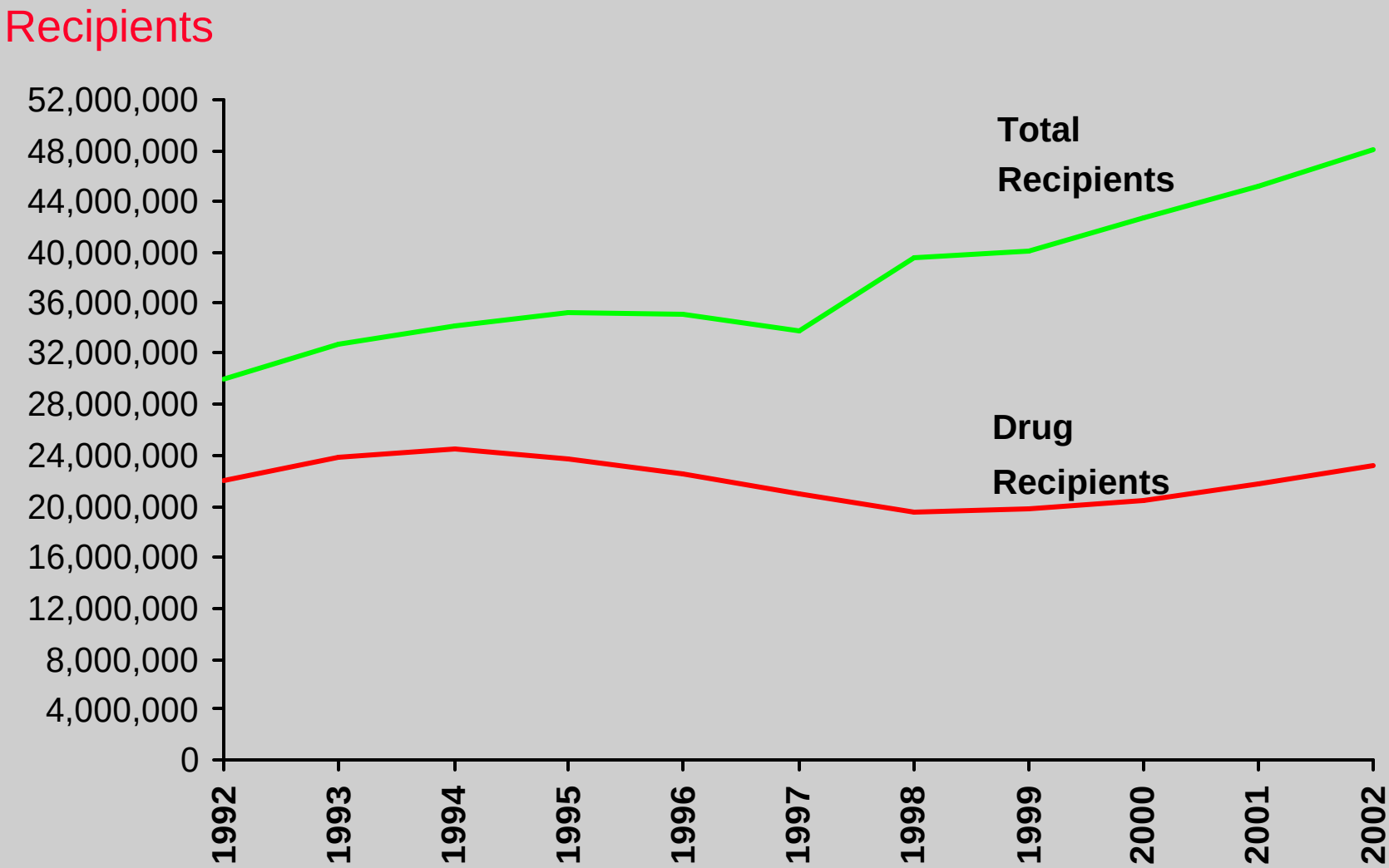
# of people	Units/person/yr (Rx/person/yr)	Cost/Unit (cost/Rx)	Rebates
Age & gender	Need	Drug of choice	Benefit mgmt.
Region	Diagnosis	Brand vs. generic	DUR
Ethnicity	Severity		Formulary
			Prior auth.

Medicaid Rx Expenditures & Rebates: 1990 to 2002 (Current Dollars)



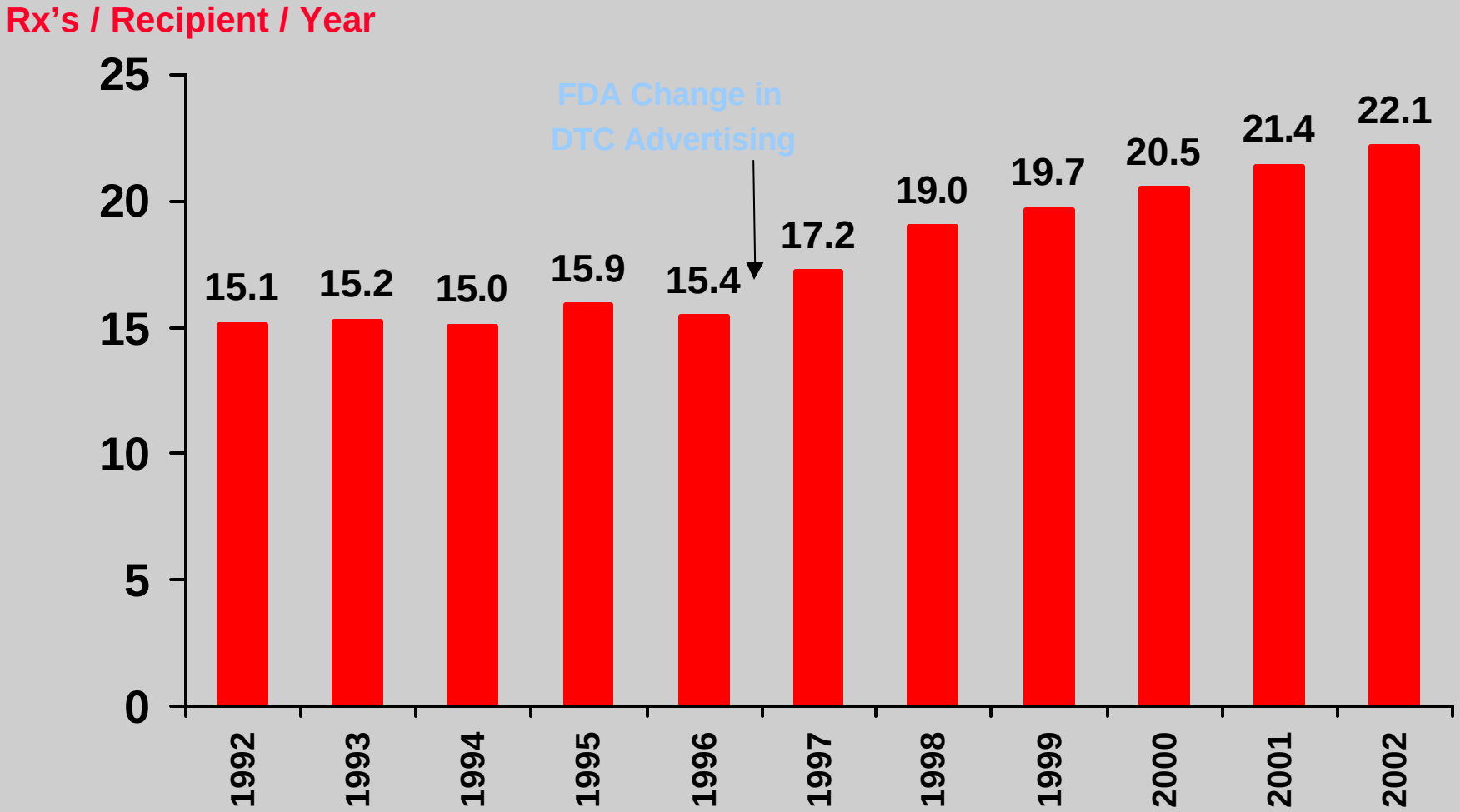
SOURCE: Compiled by the PRIME Institute, University of Minnesota from data found in Pharmaceutical Benefits Under State Medical Assistance Programs, National Pharmaceutical Council, 1976 to 2002.

Total Medicaid and Drug Recipients: 1992 to 2002



Source: P.Pine, et al. Health Care Financing Review, 1992 Annual Suppl., pp235-269; and HCFA 2082 and CMS 64 data and *Pharmaceutical Benefits Under Medical Assistance Programs,* National Pharmaceutical Council, 1975 to 2002

Medicaid Drug Use Intensity
(Rx's / Drug Recipient / Year):
1992 to 2002



Source: P.Pine, et al. Health Care Financing Review, 1992 Annual Suppl., pp235-269; and *Pharmaceutical Benefits Under Medical Assistance Programs,* National Pharmaceutical Council, 1975 to 2002

Current focus for managing the pharmacy benefit

- PDL
- Target high utilizers
  9 or more initiative
- Limit 34 days supply
- Increase co-pay for brand name drugs
- Decrease reimbursement to pharmacies

Future focus for managing the pharmacy benefit

- Generic utilization
- Prescribing patterns
  Focus on e-prescribing
- Persistency & compliance
- Self care

Future focus for managing the pharmacy benefit

- **Generic utilization**

Medicaid Generic Utilization Rates

CMS State Data 2002

National Average = 50.5%

State	Rate	State	Rate
CT	46.1	ME	50.0
DE	43.1	NC	46.7
FL	48.8	NH	55.1
IA	54.5	NJ	42.6
IL	56.2	OH	51.4
MA	51.0	SC	47.2
MD	44.8	VA	52.3

Effects of Increasing Generic Utilization

Washington Medicaid Analysis
CY2001 Data

Generic Dispensing Rate	Potential Savings
52.0%	$4,256,967
53.0%	$8,710,787
54.0%	$13,164,607
55.0%	$17,618,427

Future focus for managing the pharmacy benefit

- **Managing Prescribing patterns**
  - **Focus on e-prescribing**

Prescribing patterns

- **Initiatives that invite the involvement of the "Prescribing Community".**
  - ***Non-punitive physician profiling initiatives***
    - **Standards of practice developed with the buy-in of physician peer groups.**
  - ***Electronic prescribing pilot programs.***
    - **Will ultimately revolutionize pharmacy cost management within currently un-managed programs.**

Electronic Prescribing – The New Frontier

- Provides prescribers with patient medication histories to make informed decisions regarding appropriate therapy.
- Ability to perform true prior authorization.
  - *'Puts the "prior" back in prior authorization.'*
- Real-world Medicaid pricing information.

Electronic Prescribing – The New Frontier

- **Patient safety**
  - *IOM estimates 7,000 deaths each year due to the manual process*
  - *Between 1.5% -4.0% prescriptions are in error with serious patient risk*
- **Quality of care**
  - *Reduction of administrative tasks affords physicians and pharmacists to spend more time caring for patients*
  - *Potential to reduce medication errors*
- **Cost of errors: $2 billion / year**
- **Impact on productivity***
  - *Physician practice: 3 hours per day*
  - *Pharmacy: 4 hours per day*

*Estimated by SureScripts

Electronic Prescribing
The New Frontier – the future or NOW?

- In Rhode Island, pharmacists and physicians have launched a statewide electronic prescribing initiative. This effort is led by the Rhode Island Quality Institute, a collaboration of health system stakeholders dedicated to providing safer and higher quality health care to patients in Rhode Island, and SureScripts, which links electronic prescribing software from physicians office computers directly to pharmacy computers through a secure and efficient system.

Electronic Prescribing
The New Frontier – the future or NOW?

- Over 75 percent of the nation's chain and independent community pharmacies have already committed to using or have endorsed SureScripts Messenger™ Services
- SureScripts is currently working with physicians and pharmacies in Virginia.

Electronic Prescribing
The New Frontier – the future or NOW?

Texas Medicaid Prescriber Analysis
(1/1/03 – 3/31/03)

Number of Prescribers	Percent of All Expenditures
Top 100 of 42,158	10.0%
Top 500 of 42,158	27.1%

Estimated FY 2003 Expenditures: $1.8 Billion

Future focus for managing the pharmacy benefit

- **Managing the pharmacy benefit**
  - ***Persistency & compliance***

    "The most costly medication is the medication that is never taken or taken incorrectly."

Persistency and compliance

- A 2003 World Health Organization report states that only about 50% of people follow doctors' orders about taking their prescription drugs, and that number is as low as 40% for some conditions. The percentage of nonadherence appears to be the same across income and education demographics, and reasons include fear of side effects and not understanding doctors' orders.

Persistency and compliance

Reduce Costly “Medication-Related Problems”

- *the other “drug problem”*
- *$100 billion in costs*
- *Responsible for:*
  - 10% hospital admissions
  - 23% nursing home admissions
  - $20 million lost working hours

Future focus for managing the pharmacy benefit

- Moving from Urgent Care to Self Care

Self care

- OTC medication is used to treat over 450 medical conditions, many of which occur 10s of millions of times per year (e.g., common cold, headache, heartburn, allergies, constipation, diarrhea, insect bites an stings, sunburn, athletes foot, head lice infestations, dysmenorrhea, contact dermatitis, motion sickness, fever, acne)

Self care

- More than 100,000 OTC products are commercially available.
- Approximately 1,000 OTC products contain active ingredients that were Rx-only in recent years.
- Value of OTC drugs (3% of the healthcare dollar)
  - *Low cost (average cost $6 vs $17 Rx Generic vs $72 Rx Brand in 2001)*
  - *Reduce unnecessary heatlhcare expenditures by $30 billion/year*

Summary: Implications for Medicaid Programs

- Pharmacists can help improve drug use in Medicaid recipients which can avoid other more costly medical interventions.
- Because Medicaid recipients have more complex conditions, pharmacists have to spend more time managing their care.
- States should view pharmacists as partners in patient care that can help improve quality and reduce drug spending.

Comprehensive Pharmacists' Services Can Save Medicaid Billions Annually

- Total 2002 Drug Payments = $29,206,788,528
- Estimated Cost of Rx Drug-related Illness and Death = $11,186,884,523 (In Virginia - $66,391,733)
- Estimated Net Savings from Pharmaceutical Care Services = $6,622,635,634 (In Virginia - $39,303,906)

Source: Journal of American Pharmaceutical Association 2001; American Journal Health System Pharmacists 1997 and NACDS Economics Department

Summary: Pharmacists can help

Disease Focused:

- Diabetes
- Asthma
- High cholesterol
- Hypertension
- Heart failure
- Anticoagulation
- Depression
- Osteoporosis
- Geriatrics

Other Programs:

- Generic Utilization
- Self Management
- Compliance
- Smoking cessation
- Immunization
- Weight management
- Women’s health
- Men’s health
- Pain Management

Questions and Comments

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